CENTER FOR
ADVANCED GYNECOLOGY

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MEDICAL HISTORY INTAKE

Name: _____ Date of Birth:___/____/_____ Todays Date: ____/____/____

What brings you to our office today:_____
_____
_____
__

PERSONAL PROFILE

Marital Status: _____ Number of people in household: _____

Highest Education level completed: grade school high school college graduate degree other

Current Job/work: _____

Place of work: _____

Please list all ACTIVE treating physicians (i.e. ob/gyn, oncologist, internist, cardiologist, etc…)

Doctor's Name: _____ Specialty:_____

Doctor's Name: _____ Specialty:_____

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Doctor's Name: _____ Specialty:_____

ALLERGIES

Drug, Environmental, or Food Allergy	Reaction

MEDICATIONS & SUPPLEMENTS

Please list ALL medications, including over the counter and prescribed. Please be thorough. Use the back of this sheet for additional space if needed..

Medication Name	Strength	How often taken	Reason for taking

OBSTETRICAL HISTORY

_____ Pregnancy
_____ Full term (37+ weeks)
_____ Premature
_____ Miscarriage
_____ Abortion
_____ Living children

Where there any complications during pregnancy, labor, delivery, or postpartum?
(please circle all that apply)
C- Section (#_____) Vacuum Forceps Episiotomy
3rd or 4th degree tear Heavy bleeding after delivery
Other: _____
_____

GYN HISTORY

How old were you when your menses started? _____

Are you still having menstrual periods? Yes No

Answer the following only if you are still having menstrual periods.

First day of your last menstrual period? ____/____/____

How many days between your periods? _____

How many days of menstrual flow? _____

Periods are: Light Moderate Heavy Bleed through protection

Are your periods regular? Yes No

Do you have any pain with periods? Yes No

If yes when does pain start? With Start of Flow #____ days before flow

When was your last pap smear/HPV testing? _____/_____/_____ Was it Normal? Yes No

Have you ever had an abnormal pap? Yes No

If yes, when? _____/_____/_____ What was the abnormality?_____

Have you ever had the following:

☐ Colposcopy - Date:_____ ☐ LEEP - Date: _____

☐ Cryosurgery (Freezing) - Date: _____ ☐ Other - Date: _____

Did you have the full course of HPV Vaccine? Yes No

Do you prefer: men women both neither

Have you ever had: (Please circle all that apply)

trichomonas genital herpes chlamydia gonorrhea pelvic inflammatory disease (PID)

Birth control method:_____

If you have had a mammogram, when was the last? ___/___/____ result: normal abnormal

Do you currently or in the past have you had:

Endometriosis	Yes	No
Fibroids	Yes	No
Infertility	Yes	No
Ovarian Cysts	Yes	No

PCOS Yes No

FAMILY HISTORY: Please circle those that apply & list family member (e.g. mother)

Breast Cancer	Diabetes	Heart Disease
Chronic Pelvic Pain	Drinking/Drug Problem	Hypertension
Colon Cancer	Embolism	Ovarian Cancer
Depression	Endometrial Cancer	Pulmonary
Deep Venous Thrombosis(DVT)	Endometriosis	Stroke

Other cancer (e.g. prostate)_____

Other please specify:_____

I AM ADOPTED

HEALTH HABITS

Exercise? Rarely 1-2 times weekly 3-5 times weekly Daily

Caffeine intake (# cups per day, include coffee, tea, soft drinks, etc)? 0 1-3 4-6 >6

Tobacco use: Yes No # packs/day: ____ Age started: _____ Age quit: _____

Alcohol use: Yes No # drinks per week: ____

Have you ever received treatment for substance abuse? Yes No

What is your use of recreational drugs? Never used Past use Presently using

Amphetamines Barbiturates Cocaine Heroin Marijuana Other_____

PERSONAL SAFETY

Has anyone every...

threatened or hurt you? Y N forced you to have sex? (this includes your partner) Y N

hit, kicked, choked, or hurt you physically? Y N Are you ever afraid of your partner? Y N

OPERATIONS / HOSPITALIZATIONS

Year	Procedure or Hospitalization Reason	(Surgeon)

Last Name_____ **CENTER FOR ADVANCED GYNECOLOGY**

PAST MEDICAL HISTORY Please circle all that apply

Alzheimer's/Other Dementia	Crohn's Disease/ Ulcerative Colitis	Irritable Bowel Syndrome
Anemia	Depression	Kidney Disease
Anxiety Disorder	Diabetes	Lung Disease
Arthritis	Digestive Disorders	Memory Loss
Asthma	Epilepsy/ Seizures	Menopause
Back Pain	Eye Disease	Osteoporosis
Blood Pressure, High	Fibromyalgia	Pulmonary Embolism/DVT
Breast Cancer	Headache	Sleep Apnea
Cholesterol, High	HIV/ AIDS	Stroke
Colon Cancer	Insomnia	Thyroid Disorders
Congestive Heart Failure	Interstitial Cystitis	Urine or Bladder Problem

Other Conditions not listed above: _____
_____
_

Completed by: ☐ Patient ☐ Nurse ☐ Physician

Signature of Patient _____